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## ORIGINAL ARTICLES

### EXTENSIVE SEPTIC PROCESS ORIGINATING IN THE LINGUAL TONSIL.*


By Dr. Frank Mears Adams,

Providence, R. I.


By reason of recent contact with Indices and available literature, the writer is convinced that the occurrence of abscess occasioned by acute infection of the lymphoid tissue at the base of the tongue is either infrequent or of such common occurrence as to possess no attraction for writers. Therefore, the author, after such a library education, is undecided as to the necessity of being apologetic. However, the contact with four cases with two deaths within a period of twelve months, being a distressing and unusual experience for this community, leads us to feel that a report upon the matter may be of interest to the men of our special branch of work.

Because of removal of faucial tonsils many people, as we know, develop a compensatory function in the lingual tonsils which throws quite a burden upon them. Their anatomical position and size and peculiar contiguity to the mucosa of the lower pharynx, and the additional susceptibility to traumatic irritants involved in deglutition and other buccal manouvers expose the lingual tonsils to many insults. Some of the most distressing ambulatory cases coming to our office are those of irritation of these masses of surface lymphoid tissue, but it has hitherto been rare to see acute infections of such a degree of severity as was shown in the four cases which are here tabulated.

It is not intended to discuss all types of lingual tonsil disease in this paper, but to record one type, namely abscess formation in the upper part of the neck. This, for the purpose of demonstrating one or two rather well known features of the lymphatic system. For the sake of stressing these anatomical points, we will outline the cases with which we came in contact. These patients as we have said, present but one type of lingual tonsil disease, namely, lingual quinsy.

*Digest of thesis presented for admission to American Society of Laryngology, Rhinology and Otology, 1923. Read before Rhode Island Medical Society, June 4, 1925.

Case I.

J. W. Civil Engineer. Male. 45 years. Married. One child.

*F. H.* Mother dead. Chronic nephritis. 62. Father dead, skull fracture, 65. No brothers or sisters.

*P. H.* Measles, diphtheria and mumps in childhood. No tuberculosis or syphilis.

At 25 had severe tonsillitis. At 35 received fracture of nose. For past three winters had attacks of tonsillitis and severe frontal sinusitis. Had left middle turbinate removed one year ago. "Always troubled" with post nasal catarrh.

*P. I.* Five days before consulting the author he was treated for sore throat by contract surgeon in construction camp. Twenty-four hours after first treatment noted severe tender swelling of left upper cervical glands and had some difficulty in breathing. These two symptoms, accompanied by temperature of 101 to 104, necessitated removal to hospital where we first saw patient on April 20, 1923.

*Examination:* Stout man of 45, markedly septic. Temp. 102. Pulse 120. Resp. 40. Face flushed and somewhat cyanotic. Respiration somewhat difficult because of pressure upon larynx and epiglottis. Voice husky. Glands of left upper cervical region and cellular tissue of neck badly swollen and hard, with no areas of fluctuation. Mouth opens with difficulty. Tongue dry and swollen. Faucial tonsils somewhat enlarged. Pillars free. Left lingual tonsil greatly enlarged and projects upward into fauces between the pillars, overlapping faucial tonsil. Pus is oozing from a traumatic opening in the anterior central surface of this mass. The mass is about the size of a large English walnut. Cultures of pus taken and subsequently found to contain Strep. Viridens. Blood culture negative. Wasserman negative.

*Treatment:* Ice pack about neck. Hot saline irrigations of mouth and throat every hour. Rectal saline and tap water. Liquids by mouth. Small doses of morphine and chloral hydrate were administered during the night as patient became very restless and was in great pain.

Second day. At 9 A. M. cellulitis of neck had increased. A vertical incision into substance of the lingual tonsil mass drained an enormous amount of pus. The cervical mass was incised through the skin the same day, and much pus evacuated from an area just lateral to the upper edge of the thyroid cartilage, and over the outer edge of the sterno-mastoid muscle. Drains inserted. Hot moist dressings applied and renewed every hour. Patient became actively delirious in a few hours and tore dressing off. The parotid gland became swollen, apparently by direct extension during the night.

Third day. At 9 A. M. patient was resting under influence of opiates. Parotid swollen and fluctuating. After consultation the gland was opened and several ounces of pus exuded. Probes passed through the subcutaneous tissues showed a dissection through the cellular tissue of the cheek and neck with much necrosis and sloughing. Wet packs were placed over the drained wounds and surrounding surfaces. The patient was extremely delirious for two following days, requiring constant attendance by male nurses. No clinical record of temperature and pulse could be kept. Death on April 25th followed a maniacal outburst. Failure of respiration preceded that of heart beat by three minutes.

Autopsy revealed a sloughing connective tissue cavity extending from the cheek at the level of the left zygoma to the tissues overlying the clavicle. There was a large pocket of pus in the root of the tongue beneath the lingual tonsil, well separated by indurated tissue from the outer cervical connective tissue. All the lymph glands of this side of the neck were either broken down or were obliterated. Heart, kidneys and meninges showed no gross pathology.

CASE II.

A. G. Prison shop instructor. Male. Age 50. Married. No children.

*F. H.* Mother dead, 60. Chronic nephritis. Father dead, 65. Pneumonia. No tuberculosis. No syphilis in family.

*P. H.* Measles in childhood. Repeated tonsil disease for past five years. Attacks almost every winter and asthma of non-spasmotic type for past ten years. Worse in cold weather and usually preceded by sore throat. Never has been confined to bed for more than a day or two.

*P. I.* Consulted the author one week after onset of bad sore throat which had been treated at home by applications of iodine, sprays and gargles. Complained of swelling of right side of neck and some interference with breathing by reason of pressure upon larynx. Had not been able to swallow liquids on day of visit. He was put to bed and examination was made:

Male, 50 years. Obese. Respirations rapid and wheezy. Face cynacosed and moist. Temp. 100. Pulse 120. Tongue swollen and dry and protruding slightly. Faucial tonsils moderately enlarged and chronically infected. Right lingual tonsil mass was about the size of an Italian chestnut and was extremely tender and covered with a thick, sticky exudate.

The tissues of the right side and central portion of the neck were swollen and hard and showed no fluctuating areas. Cultures were taken from the throat at first visit and subsequently showed strep. haemoliticus.

After treatment in bed, consisting of ice pack and irrigations into mouth and pharynx, the symptoms did not improve. At the end of twenty-four hours hot dressings were applied to the neck as the indurated area had not softened and was extending across and involving the left side. At the end of the second twenty-four hours he was given gas and ether and an incision was made at the level of the upper border of the thyroid cartilage over the course of the internal jugular. An enormous abscess cavity was encountered which contained about a pint of bloody pus. This process had dissected below the deep crevical fascia and the laryngeal cartilages could be felt in the bottom of the cavity. The dissection had not halted at the mid line and a drainage opening was made on the left side of the neck. This pocket also reached upward and involved the tissues in the submaxillary region. The patient subsequently recovered and drainage ceased in about ten days.

Examination of the throat during the process of recovery revealed a gradual subsidence of the lingual tonsil mass. Subsequent treatment by removal by snare gave no undue amount of bleeding.

CASE III.

J. B. Female. Age 28. Clerk.

*F. H.* No bearing.

*P. H.* No previous illness of note.

*P. I.* Had trouble with throat for the past four

years. One week ago had considerable sore throat with much difficulty in swallowing. Two days previous to entrance noted swelling of tongue and of the tissues under point of jaw. In past twenty-four hours left side of the neck took up this process.

*Examination:* Well nourished young woman. Pale. Temp. 102. Pulse 100. Respiration 28. Tongue swollen, mouth opened with difficulty. Faucial tonsils missing (removed in childhood). Lingual tonsil mass enlarged across whole base of the tongue and covered with membranous exudate. Neck swollen from mandible to clavicle on both sides. Very tender. No fluctuating areas. Ice pack and hot saline irrigations were instituted and patient put to bed. In the course of about forty hours the patient became delirious and the left parotid and posterior auricular regions became involved in the process of swelling. The post auricular gland broke down and was incised and two incisions were also made in the upper cervical and parotid regions respectively. Large amounts of bloody pus exuded from these openings. The destruction of tissue above and below the deep fascia was extensive. The patient died at the end of four days.

Owing to delirium temperature and pulse charts were not continuously nor properly kept.

CASE IV.

F. B. Age 16. Student. Male.

*F. H.* Parents and two brothers living and well.

*P. H.* Tonsillitis. Rheumatism. Malaria. Tonsillectomy at nine years.

*P. I.* Caught cold seven days prior to first visit. Suffered from dry throat and tender tongue for past four days. Also had some trouble in swallowing as well as opening the mouth. Has had treatment by family physician who has used hot saline gargles and menthol troches. In past twenty-four hours has had some swelling in the mid portion of the neck and on the left side. This seems to be rapidly increasing.

*Examination:* Well built and well nourished male. Looked "septic." Neck swollen on the left side from the jaw down to the level of the thyroid. Mouth opened wtih difficulty. At the base of the tongue was a cauliflower mass protruding upward into the faucial fossa on the left and lying upon the tongue. There was much foul smelling exudate in the pharynx and pus could be expressed from the lingual mass by moderate pressure with a tongue depressor.

The induration of the cervical tissues seemed to fluctuate at a point opposite the top of the thyroid cartilage. An incision was made at this point and a small amount of pus was obtained and a drain inserted.

Profound general septic symptoms developed during the next two days and in spite of hot dressings the swelling in the cervical tissues refused to subside. The post auricular region became involved and there was some small amount of swelling over the left parotid. However, there soon occurred a fluctuation at the point immediately below the mid point of the lower jaw and an incision evacuated an enormous quantity of pus. During the next week four incisions were made in these cervical tissues and competent drainage was established. After recovery from this condition the patient developed a septic knee and suffered from multiple abscesses of both arms and of the lumbar region of the torso. The micro-organism obtained in throat and abscess cultures was Streptococcus Haemoliticus.

* * *

The lymphatic glands of the neck involved in this discussion are, as generally accepted, distributed as follows: Superficial glands are numerous along the course of the external jugular vein and posterior jugular vein. These are about six in number and are situated in the deep cervical fascia in the posterior triangle. A few lie in the median line of the neck below the symphysis of the jaw, one at the level of the hyoid bone and one or two above the sternum and one or two resting upon the trapezius muscle. This superficial chain receives efferent vessels from the posterior auricular glands and from the parotid and submaxillary glands, and their efferent vessels empty in turn into the inferior deep cervical glands.

The deep cervical glands number from twenty to thirty and are situated along the internal jugular and subclavian veins. They are usually described as being divided into a superior and inferior set, the superior along the internal jugular vein, above the bifurcation of the common carotid artery, and the inferior lying below the bifurcation. The superior set receives efferent vessels from the maxillary and submaxillary glands and

vessels, from the cranial cavity, the deep muscles of the upper part of the neck, the mid portion of the pharynx, the upper part of the larynx and thyroid body and from the posterior part of the tongue.

The inferior set extends downward along the internal jugular and subclavian veins. These receive efferent vessels from the superior deep set of glands and superficial cervical glands; the lymphatic vessels from the lower part of the thyroid and larynx, lower part of the pharynx, trachea and esophagus and lower part of the neck. Their efferent vessels are in intimate conjunction with the right lymphatic duct and the thoracic duct.

Thus we see that the lymphatic drainage of the base of the tongue is concerned with the superior deep cervical lymphatic glands. Dissection of these glands and efferent vessels also reveals the fact that these structures are very sizeable and can readily be injected with staining fluids to demonstrate their calibre. In a single dissection by the author upon a specimen shortly after death, and before embalming fluids had altered the tissues, a solution of methylene blue injected under pressure into the jugular lymphatic trunk readily found itself demonstrated in several deep cervical glands and in the muscles and connective tissue at the base of the tongue. This experiment was tried primarily to question the simple statement that anatomists have so often affirmed, that the lymphatic vessels of the neck are of large calibre and that transmission of infected lymph is an extremely rapid process. Here we probably have an explanation of the rapid rise of systemic sepsis and the profound reaction so often seen in acute infections involving the lingual tonsil.

The intervention of the deep superior set of glands in the system in the route to the lymphatic duct or the jugular duct is about the only outpost holding back the mass of infected lymph in acute infectious processes about the head, and this intervention explains the rather startling symptom of edema and induration of the tissues of the neck which we meet in these cases.

It will be noted that with two of our patients, cases I and III, there occurred a parotid infection which terminated fatally. It is probable, from the degree of destruction in the submaxillary region, that the infection travelled upward against the current of the efferent vessels to the lymphatic gland overlying the parotid gland. The postauricular glands in these two cases also showed much destruction. The extension of swelling to this group was secondary to the involvement of the deep cervical group, as was that of the parotid group. It is a more or less common occurrence in other portions of the body to see pathological processes push backward along efferent lymphatic vessels and produce trouble in distal portions, but the author, at least, has never had this trick before forcibly demonstrated.

In our fourth case we saw in the profound sepsis and in the subsequent pyemia and arthritis a picture of the rapid dissemination of septic material through the efferent vessels to the main trunks.

A further feature brought out by these cases is the character of the progress of the sepsis as contrasted to that so often seen in Ludwig's angina. In septic sacculation produced by infection implanting itself upon the lingual tonsil, the induration is liable to be unilateral and seems to involve the deep lymphatics, while the swelling found in Ludwig's angina is most always bilateral and perhaps more likely to involve the tissues lying close to the larynx.

In addition to the experience with the four patients whose histories are given, the author has noted a decided tendency to less extensive but noticeable and very distressing infections of the lingual tonsils occurring in patients who have subjected themselves to removal of the faucial tonsils. In many such cases we have found by using the laryngeal mirror that the epiglottis is prone to congestion and to different degrees of edema.

It is possible, if the patient is seen early enough, to avoid external incision by going into the base of the tongue by blunt dissection, but in one such attempt we encountered extensive bleeding from lingual vessels caused by extensive sloughing on the third day following initial operation. This required further anesthesia and extensive clamping. However, our experience has brought to our attention the fact that this dissection or incision into the base of the tongue is probably the best method of interference.

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References: Deaver, "Surgical Anatomy of the Head and Neck," 1910. Quain, "Elements of Anatomy," 1898. Henry Gray, "Anatomy," 1901. Knight and Bryant, "Diseases of the Nose, Throat and Ear," 1909.

# THE USE OF THE LABORATORY IN THE PRACTICE OF MEDICINE.

*By*

H. EVERETT SMILEY, M.D.,

PROVIDENCE, R. I.

There is no gainsaying the fact that the laboratory is becoming recognized as a very important asset in the practice of medicine. The findings obtained by laboratory methods are of the utmost importance, and correctly interpreted, often prove to be the deciding factor in either the diagnosis or prognosis of a case. Even routine examinations, where the tests are made blindly, have a value, for oftentimes unsuspected conditions are brought to light. The real worth, however, of a laboratory is shown in the tests applied to the individual case where clinical findings are checked up and supported or disproved by the laboratory examination.

The observations noted in this paper are made from several years' experience in the laboratories of the Providence City Hospital, the Rhode Island Hospital and Harvard Medical School. No pretense is made to originality for the ideas expressed, inasmuch as they are well known to every laboratory worker. The purpose of this paper is simply to call the attention of the physicians of the state, again to the advantages to be gained by recourse to laboratory data. All the laboratory examinations may be grouped under six heads, viz, (1) direct smears, (2) cultures, (3) serological tests, (4) animal inoculations, (5) chemical analyses, and (6) tissue diagnoses.

## 1. *Direct Smears.*

Direct smears may be made from any source and stained and examined immediately. The value of direct smears varies directly with the source of the material. As a general rule, positive findings are important and significant, while negative findings are never to be considered as final. If the clinical picture warrants, the smear should be repeated. Direct smears are commonly taken from secretions (throat, nose, sputum, urine and spinal fluid sediments, etc.), exudates (pus), blood and scrapings from skin or ulcerated surfaces. All smears should be carefully taken from the site of the lesion, and further, every examination should be made for a single definite finding so that a special selective stain may be used. For example, a throat smear may be examined for diphtheria, Vincent's angina, streptococci, pneumococci, spirochaetes, etc., and in each instance a special stain is called for. Any smear sent to a laboratory for "general examination for organisms" is of little value, and mitigates the report. Whenever a smear is submitted to any laboratory, it should be specifically stated what is to be sought. If more than one condition is under suspicion, then more smears should be submitted, together with the full history of the material. An intelligent report cannot be given otherwise. As a general rule, all smears submitted for examination are too thick; the material should be evenly and thinly spread out on a glass slide. The use of a second glass slide to press out the material is to be recommended, provided, of course, that the slides are separated after the smear is made.

The following conditions may be diagnosed by direct smear: Diphtheria, Vincent's angina, thrush, tuberculosis (sputum, etc.), syphilis (chancre or mucous patch), gonorrhoea (pus from eye or genito-urinary tract), rabies, malaria, blood and stool parasites, and the anaemias (blood), while other conditions may be suspected as a result of the smear examination, e. g., pneumonia (sputum), and streptococcic sore throat. It should be noted here that it is of prime importance that every laboratory finding should be confirmed by clinical evidence and every clinical diagnosis should be confirmed by a laboratory finding so far as this is possible. It is most essential for a correct report that the material submitted for examination be carefully obtained directly from the site of the lesion to give the laboratory a "fair chance."

## 2. *Cultures.*

It is in the studying of cultures taken from the site of the lesion that the laboratory gives the most positive and satisfactory assistance. The finding of an organism in a lesion which culturally and seologically conforms to a specific type, demonstrates conclusively the probable etiological factor. As a general rule, all pathogenic organisms require special selective media for growth, and furthermore require optimum temperature conditions. Moreover it is absolutely essential that the submitted material be fresh, and that it be immediately inoculated on a suitable medium and incubated at once. The nearer one approaches these ideal conditions, the more satisfactory will be the report.

As in the case of direct smears, it is desirable that the laboratory be consulted so that the proper medium may be used. For example, blood agar plates should always be used when looking for hemolytic streptococci, and dihptheria cultures should be made on Loeffler's blood serum, to get the best results. Many of the important pathogens (e. g., streptococci, influenza, pertussis, gonococci, meningococci, pneumococci, etc.) will not grow at all unless the most favorable readily when exposed to air, so that unless the material is fresh, a false negative report will be given. The modern laboratory has on hand at all times special selective media for culturing these organisms, together with the different "sugar media" to help in the cultural determinations.

The diagnosis of any condition known to be caused by a specific organism may be confirmed by laboratory findings, hence it is self evident that the laboratory should be used to the fullest extent.

The taking of blood cultures should be encouraged in any febrile condition, the best time being at the height of the temperature curve. The organisms which are commonly sought for in the blood are streptococci, staphylococci, pneumococci and typhoid. The finding of staphylococci should always be carefully checked by absolute sterility in technique, for they are very common contaminating organisms and are rarely found in the circulating blood, inasmuch as the organism has a tendency to become walled off in a localized abscess in some part of the body. The finding of staphylococci in the blood stream means that the focus of infection has broken down and is "feeding" the organisms into the circulation.

3. *Serological Tests.*

The serological tests are those which make use either of the patient's serum or of diagnostic "immune" serum. Of the former, the most common are the Wassermann test of syphilis (and similar tests as the Sigma and Kahn tests) and the Widal test for typhoid; and of the latter are the tests using "immune" serum to react with a specific organism, as the agglutination of a suspected typhoid or dysentery culture by its respective serum, and the "typing" of pneumococci and meningococci.

In the first case, the patient's blood should be drawn in a clean, prefarable sterile tube, and should be fresh. Hemolyzed or contaminated blood always gives an unsatisfactory test. While the Widal test may be made using a drop of blood, it is much more preferable to use serum so that accurate dilutions may be made. Since so many people have had prophylactic inoculations for typhoid, the Widal test is of less value, for nearly any febrile condition will cause the reappearance in the blood stream of the agglutinins that were not detectable previous to the fever. The most satisfactory diagnosis of typhoid fever is the finding of the organisms, either in the blood or in the feces and urine. The diseases which are commonly diagnosed by serological methods are syphilis, glanders, typhoid fever, the dysenteries, lobar pneumonia, and cerebrospinal meningitis. Complement fixation tests for gonorrhoea and tuberculosis are not sufficiently well developed to be of any practical value.

4. *Animal Inoculations.*

The commonest tests involving the use of animals are pneumococcus typing, in which case white mice are used; and the inoculation of guinea pigs either with suspected tuberculous material, or for determining the virulence of a diphtheria culture. In the first mentioned instance, sputum (not saliva) from a suspected case of pneumonia is injected intraperitoneally into a white mouse, and usually within 24 hours a pure culture of pneumomocci may be cultured from the heart's blood of the mouse, to be typed later, and the washings from the peritoneal cavity may be typed directly. Similarly, material suspected of being tuberculous, whether sputum, urine or exudate, when direct smears or concentration methods have failed to demonstrate tubercle bacilli, may be injected subcutaneously into a guinea pig and, if positive, the pig will show definite lesions within six weeks. By animal inoculations, also, the human type of tubercle bacilli may be differentiated from the bovine, the latter being much more pathogenic for animals, particularly rabbits.

Guinea pigs are also used exclusively for the determination of the virulence of a diphtheria culture, either using the intradermal or the subcutaneous route for inoculation. Guinea pigs are used for the detection of rabies when the direct smears fail to demonstrate the Negri bodies.

In any laboratory where research is followed animals are widely used.

5. *Chemical Analyses.*

Chemical analyses may be applied to the blood, cerebrospinal bluid, urine, stools, stomach and duodenal contents. Blood chemistry is rapidly coming to the front and is much relied on in cases of diabetes, nephritis, acidosis, gout, comatose condition, rickets, etc., to establish both the diagnosis and the prognosis. It is very essential in all such analyses, that the blood be taken just previous to the test and that it should preferably be taken before breakfast (on a fasting stomach) or at least four hours after a meal. The value of the readings decrease the longer the sample stands, so that every specimen submitted should be labelled with the time of taking. As in the case of the bacteriological examinations, each specimen should be submitted for a specific analysis, and not for a "general examination." Further, the advice of the chemist should be sought in selecting the tests to be made, so that the most pertinent information may be obtained for the specific case.

The chemical examination of the contents of the gastro-intestinal tract involve tests for acidity, evidence of digestive activity, bile and blood (fresh and occult) and all specimens should be carefully taken to have the results of the analyses of any value.

6. *Tissue Diagnoses.*

Tissue may be obtained either at biopsy or necropsy and after it has been "fixed," sections may be cut and studied for pathologic histological changes. For this purpose the specimen should be put into the fixing fluid as soon as possible after removal from the body, to avoid post-mortem changes which mask the condition. It is because of these "normal" post-mortem changes that autopsy material decreases in its value the longer the delay after death. If proper fixing material is not at hand, the tissue should be kept moist with strong salt solution until the specimen can reach the laboratory. Dried specimens are of little or no value. For a rapid diagnosis, a frozen section may be made, using carbon dioxide, when the section may be cut immediately. The picture from the rapidly fixed tissue is oftentimes distorted, hence it is a good general rule that only positive findings should be considered as final. By using the "acetone" method, stained sections may be prepared in a few hours; this is preferable to the freezing method. The usual period of fixation, cutting and staining takes four days, but the time may be lengthened or shortened.

In conclusion, it is hoped that this brief exposition of the common procedures will stimulate interest in, and the use of, the laboratory. It should be borne in mind that the careful studying of a case from the laboratory point of view often makes use of all the above described six routes of study, but the information gained is the end which certainly justifies the time and the methods used. When one considers how important it is to establish the diagnosis of a case, both from the individual point of view of the patient or the physician, and the broader, far-reaching consideration from the standpoint of public health and general hygiene, then it should be more readily recognized that the diagnostic laboratory fills an important and responsible place in any community. There can be no more valuable contribution to the advancement of careful medical practice than the accurate information supplied by a well equipped and competently directed laboratory.

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Dr. Howard E. Blanchard announces to the profession that he has returned after a special course in plastic surgery of the face and facio-maxillary surgery at the University of Paris and St. Louis Hospital, Paris, France. In connection with his regular specialty, he is prepared to devote particular attention to rhinoplasty: *a,* acquired deformities; *b,* congenital deformities; burns, contractures, cicatrices; malignancies of the head and neck; cosmetic surgery; urano plasty—cheiloplasty; surgery of the jaws; protheses and dental splinting.

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| H. A. MANCHESTER | *President* | Saylesville |
| ROBERT T. HENRY | *Secretary* | Pawtucket |

**PROVIDENCE**

Meets the first Monday in each month excepting July, August and September

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| ALBERT H. MILLER | *President* | Providence |
| P. P. CHASE | *Secretary* | Providence |

**WASHINGTON**

Meets the second Thursday in January, April, July and October

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| M. H. SCANLON, M.D. | *President* | Westerly |
| WM. A. HILLARD | *Secretary* | Westerly |

**WOONSOCKET**

Meets the second Thursday in each month excepting July and August

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| J. V. O'CONNOR | *President* | Woonsocket |
| J. M. MCCARTHY | *Secretary* | Woonsocket |

**Section on Medicine**—4th Tuesday in each month, Dr. Charles A. McDonald, Chairman; Dr. C. W. Skelton, Secretary and Treasurer.

**R. I. Ophthalmological and Otological Society**—2d Thursday—October, December, February, April and Annual at call of President Dr. Frank M. Adams, President; Dr. Jeffrey J. Walsh Secretary-Treasurer.

**The R. I. Medico-Legal Society**—Last Thursday—January, April, June and October. Dr. Frederick Rueckert, President; Dr. Jacob S. Kelley, Secretary-Treasurer.

## EDITORIALS

### THE DOCTORS' DUTY

The present spectacle of a number of cases of smallpox within the limits of our State and new cases occurring over a period of a number of months, as well as newspaper accounts of cases of typhoid fever in our midst, bring very forcibly before us the doctors' duty regarding preventive medicine. With vaccination against smallpox, and inoculation against typhoid fever—too thoroughly demonstrated to need any present day defense—we yet witness a tendency among some of the medical profession to procrastinate in the case of these preventive measures. It is not only in the maintenance of health, but also in preventing the unpleasant quarantines, necessary economic losses and much unhappiness caused by illness, that we are concerned, and it is, therefore, the duty of every physician to practice immunization against disease and also to go out into the highways and byways and preach the importance of constructive measures demonstrated by modern medicine to

preserve the health of our people, and help in maintaining their happiness and efficiency. Let the public health officials come frequently before our own medical gatherings and urge upon us the responsibility which we have, and let each one of us appoint himself or herself a committee of one to do our utmost to establish the medical profession as a progressive, resourceful force for public welfare.

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## SMALL POX.

The small pox situation is this state, while not alarming, is certainly disquieting. The outbreak began last spring, and should by this time, through intensive effort, have been put at an end. On the contrary, it shows signs of spreading. Summer is the most favorable time for stamping out the disease, yet it still lingers, and cold weather will make it much more difficult to control. It will be little short of a miracle if a considerable outbreak does not develop during the fall and winter.

Fortunately for the victims, but unfortunately for health authorities, the disease is of a rather mild character. Physicians see so little of it now-a-days that the diagnosis is not always properly made. More often the physician is not even called, so that many are entirely overlooked, and others not recognized until other people are exposed.

But there is no assurance that the cases will continue to be mild. Detroit recently was visited by a large outbreak of the disease. At first, the fatality was very low, but a new and severe strain was introduced in the person of a Canadian, and before the outbreak was over there were 1,866 cases and 163 deaths, many of which were of the hemorrhagic type. This severe form of the disease visited Duluth and Minneapolis. In Minneapolis during the last six months of 1924 there were 860 cases and 219 deaths. The disease has been mild in the United States for over twenty years, but these and other recent outbreaks indicate that this mild form will probably be replaced by a more severe strain.

During an eleven year period, from 1913 to 1923, there were registered in this country over five hundred and seventy-nine thousand cases of small pox. We who pride ourselves on the great strides taken in recent years in disease control must hang our heads in shame when the control of small pox is mentioned, particularly when the method of prevention has been known for over a century and a quarter. Rhode Island has been very fortunate for many years, having had fewer cases than any state in the Union. There were only twenty cases during the eleven years' period, but this is no sign that an outbreak of considerable proportions is not near at hand. Rhode Island is one of the four states that has a law which requires that every school child must be vaccinated before attending school. Outside the City of Providence, it is poorly enforced, if at all, so that there is a large number of non-immune children and native born adults. All immigrants are vaccinated before they are allowed to enter the country. Vaccination in childhood is not alone sufficient, for it should be repeated two or three times during adult life, and always when an outbreak occurs.

The health officer, at best, can go little farther than he is empowered by law, and what he can accomplish by publicity until an epidemic appears. But why wait for a catastrophy to bring action? One of the most effective health agents is the general practitioner. There was a time when he felt the obligation resting upon him, and kept his families vaccinated. People will listen to him when words of advice from a health officer fall on deaf ears. Now the physician has either lost his sense of duty or passed the responsibility over to the authorities. No program of health can be carried to a successful conclusion without the help of the medical profession as a whole. A health officer's hands are tied unless he can obtain their co-operation.

No matter how efficient a health department may be, the physician is morally bound to assist in every way he possibly can, and in the matter of vaccination the family doctor should go back to the practice of former days and guard his families against small pox. It is as much a part of his duty as visiting his patients when they are ill.

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## RHODE ISLAND MEDICAL SOCIETY CLINICAL CONFERENCES COMMITTEE.

In partial recapitulation and in accordance with a vote taken at the June meeting of the R. I. Medical Society, Dr. DeWolf, President, ap-

pointed the undersigned committee to consider the matter of clinical conferences to be held during the ensuing year.

This committee met on August 18, 1925. All but two of the members were present. The details of the proposed clinical conferences were discussed and voted upon, all the members of the committee taking a very lively and active interest in the matter.

It was voted that a letter should be sent to the trustees of the various hospitals, asking their co-operation in the matter of holding these clinics. Another letter was to be addressed to the visiting staff, informing them that the committee of the R. I. Medical Society might call upon certain members of their staff to give lectures and clinics during the coming year, and asking for their co-operation.

It was decided to hold the clinical conferences in the various hospitals of the state, to begin November 1st and to end by May 1st. In the Providence group there will be clinics every Tuesday, Wednesday and Friday mornings, between 11 and 1, and these clinics are divided into six different courses, medicine, surgery, obstetrics, gynecology, eye, ear, nose, throat, pediatrics, and infectious diseases. Clinics will be so arranged that there will be no confliction, making it possible for a physician to attend any or all of the clinics.

In this program of clinical conferences, the four other hospitals in the state are planning to take part; namely, Memorial Hospital, Pawtucket; Woonsocket Hospital, Newport Hospital and the new hospital at Westerly, R. I.

By the first of October, all these clinics, with their dates, subjects and lecturers, will be in printed form, ready to be mailed to all the physicians in the state. The secretary of the meeting who arranged for this educational program, is the secretary of the R. I. Medical Society, and the treasurer of the meeting is also the treasurer of the R. I. Medical Society.

It was thought best to make a charge for these conferences to defray the expenses incident for printing and other necessary expenditures. A charge of $5.00 is to be made for one course, and $10.00 for two or more, and all the physicians desiring to attend these clinics will be asked to fill out a matriculation card, which will be sent him, designating the course or courses which he desires to attend.

The success of this undertaking depends, certainly this year, upon the willingness on the part of the physicians of the state to co-operate with the committee who have arranged a definite, and it is hoped, a satisfactory group of lectures and clinics. Whether it is a success this year and will appeal to physicians in subsequent years, of course, depends upon how well the men who are selected to conduct these clinics have done their work.

It is hoped that every one will co-operate this first year, at least, to try to make the experiment a success.

Respectfully yours

Dr. N. C. Baker
Dr. F. H. Beckett
Dr. F. N. Brown
Dr. John Champlin
Dr. Halsey DeWolf
Dr. J. E. Donley
Dr. A. H. Harrington
Dr. F. V. Hussey
Dr. J. W. Leech
Dr. A. D. Mead
Dr. J. E. Mowry
Dr. I. H. Noyes
Dr. D. L. Richardson
Dr. W. C. Rocheleau
Dr. A. H. Ruggles

## SOCIETIES

### The Rhode Island Medical Society
### 114th Annual Meeting.

The 114th annual meeting of the Rhode Island Medical Society was held in Providence, Thursday, June 4, 1925, at the Medical Library Building, consisting of an all-day meeting.

The morning session was called to order at 11 A. M. by the President, Halsey DeWolf.

The minutes of the March meeting and the annual meetings of the Council, and the House of Delegates were read by the secretary and accepted.

Dr. F. N. Brown exhibited the emblem adopted by the American Medical Association and by this Society as the official emblem for its members to attach to their automobiles.

Memorials upon the death of Dr. Wm. F. Barry, Dr. Gonzalo E. Buxton, Dr. Henry J. C. Corrigan, Dr. Edw. M. Harris, Dr. Harold M. Howard, Dr. Frank C. Pagan, Dr. Julius J. Robinson, Dr. Gardner T. Swarts, Dr. Harry V. Carroll, were read by the secretary in the absence of Dr. Clarke, chairman of the Committee on Necrology.

Delegates from other state societies were then presented: Dr. Sheldon S. S. Campbell, Middletown, Conn.; Dr. Wm. O. Hewitt, Attleboro, Mass.; Dr. R. H. Sartwell, Cranston, R. I. (Mass. Society); Dr A. L. Patch, Windsor, Vt. (Dr. Roger M. Griswold, Kensington, Conn., was unable to attend on account of the extreme heat.)

Dr. Sheldon S. S. Campbell, Middletown, Conn., brought the good wishes of the Connecticut State Medical Society.

"Mr. President, and members of the Rhode Island Medical Society, I am the one who has been sent as delegate and to express the good wishes of the Connecticut State Medical Society. It gives me great pleasure to act in this capacity. I do not think I have anything of especial interest to place before you as I gather from your very capable secretary, Dr. Leech, that things here are done very much as they are over in Connecticut. You probably are all more or less familiar with the very unpleasant condition in Connecticut as regards licensing physicians, and the fraternity has not been remiss in its efforts to throw its weight on the right side. It has been impossible for us to get even an opening. However, we have in a quiet way used our influence and a bill was presented and it met with very strenuous objection. We did eventually bring out of the wreck another bill which, although it does not give us just what we wish, it does give us something, and that bill is a commission of laymen to pass on the qualifications of applicants. This is a decided step forward. Another point I might mention is the fact that we, I believe like yourselves, have an annual meeting in the spring and a semi-annual in the fall. The semi-annual meetings have been somewhat of a disappointment. We decided to hold these meetings with one of the smaller sections and the facilities and hospital contact have been such that it did not result in a very enticing program, and the attendance was very unsatisfactory. We thought the state society meeting with one of the smaller organizations would be worth while but it did not seem to be. We, therefore, have decided, after having been cordially invited by the Yale Medical Staff, to develop a clinical department under the auspices of Yale. We have a large committee of various members of the county organizations working on this at the present time. We hope to have a three or four day session where a man can come in and get some written matter if he is so disposed. The state and the local county organization will be decidedly benefited, and we believe it will be a pleasure to all concerned. Again I assure you that I am pleased to be with you."

The President responded that the Rhode Island Medical Society had paid a great deal of attention to the condition in Connecticut, and the Connecticut new law referred to, it being a matter of interest to all.

Dr. William O. Hewitt, Attleboro, Mass., brought the good wishes from the Massachusetts State Society:

"Mr. President and gentlemen, as delegate from the Massachusetts Medical Society I am very pleased to bring to you from the President, Dr. E. H. Bigelow, and the Secretary, Dr. Burrage, the best wishes of the Society at this time. The annual meeting of the Massachusetts Medical Society will be held in Boston, at the Copley Plaza Hotel, Tuesday and Wednesday, June 9th and 10th, and I assure you that any member of the Rhode Island Medical Society who would like to come to that meeting will be welcome by every member of the Society."

Dr. Ransom H. Sartwell, Cranston, R. I., also came as a delegate from the Massachusetts Medical Society:

"Mr. President and members of the Rhode Island Medical Society, as I am now a member of the Rhode Island Medical Society I assume a dual personality by being a delegate from the Massachusetts Society. It is really a pleasure to be able to come as a delegate from the Massachusetts Medical Society and also of the Rhode Island Society. I wish to second the remarks of Dr. Hewitt relative to the Massachusetts Society and I shall be very glad to take to the Massachusetts Medical Society's next meeting the report of this Society."

Dr. A. L. Patch, Windsor, Vt., brought the good wishes of the Vermont Medical Society.

"I am glad to come back to this meeting. I have been in Vermont now for 12 to 13 years, yes, 14. I joined the Society there 12 years ago. Each year when the names of the delegates elected from other states to the Vermont Society have been read, and there have been so few that have answered to the roll call, I made up my mind this year if I were elected from Vermont as delegate to Rhode Island I would show up. I take this opportunity to mention something about the Society. The men come from small towns and we make a two-day meeting. It comes about the 8th or 9th of October and comes when the foliage is at its best. This year, on account of the late spring and late start, it will be best in October, and if any of you have not been through Vermont in October don't miss the opportunity if elected delegate to Vermont meeting to come up. There is no state in New England that has better roads. The meeting will be held at St. Johnsbury this year. We may not have the facilities of Providence, or those the Massachusetts Society has for meeting in Boston, but we generally have an attractive program. Come up to St. Johnsbury."

Dr. Eric Stone, secretary of the Fiske Fund, made the following annual report:

"Mr. President and Members of the Rhode Island Medical Society:

It is my privilege to submit the 90th annual report of the Trustees of the Fiske Fund to this Society.

No essays were submitted in competition for the 1925 prize. The title offered was 'Plastic Surgery.'

The Trustees offer for the 1926 contest a prize of $300.00 for the best essay on the following subject, 'Recent Progress in the Prevention and Treatment of Scaratina, Measles and Diphtheria.'

The Trustees present the following financial report:

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| There is on deposit at the R. I. Hospital Trust Co., Acct. No. 17841 | | |
| Balance from last year... | $318.17 | |
| Interest to April 30, 1925 | 14.86 | |
| Received from Acct. No. 25312 ..... | 728.00 | |
| Less bills paid..... | 677.95 | |
| Bal. on hand June, 1925.. | | $383.08 |
| On deposit at the R. I. Hospital Trust Acct. No. 25312 | | |
| Balance from last year... | $11,242.88 | |
| To Acct. No. 17841..... | 728.00 | |
| Interest to Jan. 30, 1925.. | 432.48 | |
| Bal. on hand June, 1925.. | | 10,947.36 |
| On deposit at the Providence Institution for Savings | | |
| Balance from last year... | $674.03 | |
| Interest to Jan. 1, 1925... | 27.22 | |
| Bal. on hand, June 1, 1925 | | 701.25 |
| Total balance on hand, June 1, 1925 | | $12,031.69 |

Respectfully submitted from the Board of Trustees,

ERIC STONE"

The President read a letter of regret from Dr. W. W. Keen of Philadelphia, Honorary Fellow of the Rhode Island Medical Society, on his inability to attend the meeting.

The following papers were read:

"Septic Processes Originating in the Lingual Tonsil," Dr. Frank M. Adams, Providence, R. I.

Discussed by Dr. Gerber:

"I was very much interested in the excellent paper on Septic Processes in the Lingual Tonsil, and the thought came to me that a certain amount of acute infection might be avoided by paying attention to the early hyperplastic changes which take place shortly after enucleation of the faucial tonsils in certain cases. In the past three or four years I have had the experience of X-raying some 20 or 25 cases of hyperplastic lingual tonsils. Some of them were not cases for any operative procedure but the majority were cases in which there had been previous enucleation and later referred for X-ray. None of these cases were acute septic conditions but all of the cases chronic hyperplastic and chronic infection; others were hyperplastic with irritating condition affecting the epiglottis and certainly later the vocal cords especially noticeable in singers and elocutionists. Not all, but a great majority, of these cases were cured. Practically all the cases that had prolonged local treatment to the lingual tonsils by the process of silver nitrate, etc., were relieved temporarily or not at all. I have found that early attention to infected lingual tonsils lessens the danger of scar tissues that is always present. This particular treatment given to these early cases might prevent for many years acute infection as Dr. Adams pointed out."

"Aberrant Thyroid with Report of Two Cases,"

Dr. Frank E. McEvoy, Providence, R. I.
"Treatment of Eclampsia," Dr. John W. Sweeney, Providence, R. I.

Discussed by Dr. Buxton and Dr. DeWolf.

Dr. Buxton: "I enjoyed Dr. Sweeney's paper very much. There isn't anything very much to add to it. He has covered the ground very well. One point I might bring up—the question of recurrent toxemia of pregnancy. A certain number of cases that have eclampsia are bound to have it again. You never know which ones are going to have it so it is well in these eclampsia cases to consider them all of sufficient type for recurrent toxemia and by beginning treatment with this in view a great many cases may be saved in second pregnancy from becoming toxic. A certain number of these cases develop chronic nephritis from their eclampsia and of course with the kidneys temporarily damaged subsequent pregnancy will have difficulty."

Dr. DeWolf: "If any of you visit the Lying-In Hospital I feel certain you will find there this general outline as given by Dr. Sweeney in the individual method of treating eclampsia and with extremely good results. I do not believe the quoted figures are over worked. The hospital is having good results there and with a very low mortality."

Dr. Roland Hammond, delegate to the American Medical Association made a report as follows:

"As your delegate to the House of Delegates of the American Medical Association for the past two years I wish to give a report of my services. I think in the past there has not been much of a report given to the Society and I learn from the New England delegates of the other states that often our delegate did not qualify and attend the meeting. This is my second year and it is a good deal like being in Congress. They hardly know you are there the first year, not until the second year. The House of Delegates is organized similar to the House of Representatives in the National Congress with so many delegates from the different states. There are 150 delegates included in the states from the different sections, and there is propaganda to increase this to 175. I was much impressed with the class of delegates from all over the country, evidently men of some prominence in their locality, and they attack their projects seriously and vigorously. The secretary, and the speaker are very capable men and as far as I can see every one is working for the best interest of the medical profession as a whole, and the only political play is some small local election and there is some jockeying done in that way, but as a whole the interests of the medical profession are looked after. I believe the American Medical Association to be the greatest association of its kind in the world; it is the largest general association and I believe the best conducted. Many of you will be surprised to know that they turn over $1,500,000 a year in that organization. Now to take up briefly a few of the points that were handled at this meeting: The question as to who is a member of the American Medical Association, and who is a Fellow. A member of the Rhode Island Medical Society being a member of the state Society automatically becomes a member of the American Medical Association. A Fellow is a member who pays $5.00 and receives a *Journal*. There are 9,000 members and only 5,600 Fellows and there is a great propaganda to increase the number of Fellows. Its publications have a circulation of 85,000; twenty years ago the circulation was 25,000. The *Hygeia* is a very good journal and its circulation is advancing rapidly. The comments made upon it show it is finding a place among the laity.

"The Bureau of Investigation is a publicity department, a department for investigating various personal matters. Their work is an endeavor to answer questions from individual physicians. They look up the questions submitted to them; questions upon patients, etc., and you receive in return a little pamphlet covering the question which often answers the whole question.

"The question of the Life Extension Institute and other similar institutions throughout the country; they not only deprive the physicians of a legitimate business but are giving out reports which are many times displeasing to patients. To show how strong the feeling was one of the Board of Trustees from Louisiana, and one of the Board of Directors of the Life Extension Institute of New York, stated he had no reason to change his mind regarding the methods of the Life Extension Institute, failed for re-election.

"Another point of great importance was the advance of the State Medical Veteran Bureau. Many of you may remember the Act of 1924 regarding

the Veteran Bureau; the directors authorized to give hospitalization to any veteran who served in any war since 1897 for any indefinite length of time, preference given to those veterans who were most needy, and an Act authorizing traveling expenses so that a patient in the northeast corner of Tennessee might receive traveling expenses to the southeast corner of Tennessee to receive indefinite treatment for some illness which had originated any time since his service. The Board of Trustees stated that the medical profession was willing to help veterans of war but felt it absolutely unjust for the Government to take over the care of the hospitalization of any veteran suffering from any disease, no matter what, with the only qualification being that he was a veteran and must remain in a hospital indefinitely. The Board of Trustees stated that the Government did not authorize the veteran to go to the commissary department for food, coal, and clothing, and asked how this would be received by the grocer and the merchant. There is something each one of us can do to help the doctors in the country—the question of the legislation at Washington. It is well recognized that to prevent a bad law is to prevent it before it gets upon the books. There are many laws in force affecting physicians. Dr. Woodward is now the official observer at Washington and I hope he may not become a lobbyist, for if any representative in the medical profession should become known at Washington to be a lobbyist it will be "all off" with us there. There are three regulations in the Treasury Department which we should do our utmost to have repealed.

"The tax on narcotics of $3.00 which we all pay is a war measure and should be rescinded.

"Regulations regarding the deduction from income of the expense for attending medical meetings.

"Third—Expenses of post graduate studies. Although the officials of the American Medical Association have had a hearing on this they have never been able to get it rescinded.

"It was brought out that the only way to do this is each physician to appeal to his Senator and Representatives personally to investigate at least these three regulations; get them to go to the Treasury Department when they return to Washington and to have a personal interview and place the matters before them."

The President remarked that the above matters had been brought up at the meeting of the House of Delegates and referred to the Committee on Legislation so there was no action to be taken on the part of the Society.

Col. L. M. Maus, who was to have a paper on "Hydrotherapy with Special Reference to the Radio-Active Waters of the United States," failed to make an appearance.

The President read the following telegram from Dr. Franklin Martin regretting his inability to attend the meeting and requesting Dr. Frank Leslie to represent him on the Gorgas Memorial.

"Unexpected developments prevent my accepting your kind invitation to speak on Gorgas Memorial before Rhode Island Medical Society. Have requested Dr. Frank Leslie, my associate director, to represent me and read statement I had expected to present. Trust this is agreeable to you. Franklin Martin."

The aims and purposes of the Gorgas Memorial were then presented bv Dr. Frank Leslie, and the President approved the support of the excellent cause.

A recess was declared for lunch which was served in the Library Building.

The afternoon session was called to order at 2 P. M. by Dr. Halsey DeWolf.

The following papers were read:

"The Heart and Its Management in Hypertension and Chronic Nephritis," Dr. Jas. P. O'Hara.

"The Treatment of Auricular Fibrillation," Dr. Samuel A. Levine.

"A Study in Experimental Animals of the Cause and Treatment of the Serious Reactions Followig Quinidine Sulphate," Dr. Burgess Gordon.

"The Heart and Its Management in Hyperthyroidism," Dr. Cyrus C. Sturgis.

"The Heart and Its Management in Hypothyroidism," Dr. Henry A. Christian.

The above papers were discussed by Dr. Fulton and Dr. Burgess.

Dr. Fulton: "After listening to the series of such excelent papers I think discussion might be dispensed with even on a cool day. I shall take very little time today. Every one must be impressed with these papers covering cardiac problems and the general use of medicine. There are

points I would like to say a word about. In regard to quinidine, I think it is generally used by a good many, and I know a good many men are feeling that they may have over done cases. The only way in which they can be satisfactorily handled is by treating the hypertension first and the cardiac condition later."

DR. BURGESS: "Every member of this Society would like to have the opportunity to express his appreciation of Dr. Christian's and his associates' papers, and I hope they will take this as coming from all of us. However, I would like to mention a patient that I was impressed with at this time. Dr. Sturgis mentioned a patient who had an increasing goiter for 35 to 45 years, finally becoming toxic. This patient I have reference to had a pulse of 145 to 180 while lying unconscious and delirious. The patient was in bed, unconscious, and while watching through the nights, being at the bedside for several nights, about eight feet from the bed we could count her pulse the sounds were so loud. We presumed it was the cardiac apex striking one of the ribs. After 48 hours, having a pulse of about 180 it dropped to 106. As a last resort the patient was given a cold pack; actually packed ice about her. Shortly a change took place and she really recovered. We had no reason for using a cold pack at the time; just a chance suggesting itself to save the patient's life."

A rising vote of thanks was then tendered Dr. Christian and his associates.

The Secretary presented to the Society the newly elected President, Dr. Halsey DeWolf.

The suggestion of the President in his annual address relative to the formation of clinical conferences met with enthusiastic endorsement from several members and the President was impowered to appoint a committee for that purpose.

Adjourned.

The annual dinner was held at the Metacomet Golf Club at 6:30 P. M.

The Anniversary Chairman, Dr. E. D. Clarke, Woonsocket, R. I.

Speaker, Dr. George B. Magrath, Boston.

J. W. LEECH
*Secretary.*

The September meeting of the Rhode Island Medical Society was held at Westerly, R. I., September 3, 1925. The Fellows were the guests of the Washnigton County Medical Society who provided a most enjoyable day's outing. The Society gathered at 10:30 at the new Westerly Hospital and were conducted through the hospital by members of the staff. Following the hospital inspection visit was made to Watch Hill where bathing privileges were furnished by the local society. At 2 o'clock a most enjoyable dinner was served at Oaks Inn, approximately 100 members being present.

After dinner the President, Dr. DeWolf, reported upon the activities of the Committee on Clinical Conferences which it was voted that he appoint at the June meeting, and explained in considerable detail the plan of the conferences at the various hospitals throughout the state.

It was expected that Dr. Rogers, who was the prime mover in the formation of the Washington County Medical Society, would be present to address the Fellows with reminiscences of the early days of that Society. He was unfortunately prevented from being present by illness and the paper which he had prepared on the subject was read by the Secretary.

The Chairman of the local Committee of Arrangements, Dr. Champlin, then introduced Dr. Michael H. Scanlon, President of the Washington County Medical Society, who, in a short paper, explained the aims, purposes and accomplishments of the Westerly Physicians' Association in its relation to the individual physician and the community at large.

The Committee of Arrangements of the Washington County Medical Society who arranged the very enjoyable program for the day comprised Dr. John Champlin, Dr. Chester G. Savage, Dr. Samuel C. Webster, Dr. Michael H. Scanlon.

Dr. DeWolf, in adjourning the meeting, tendered the thanks of the Rhode Island Medical Society to the Washington County Medical Society for its courtesy and hospitality.

J. W. LEECH
*Secretary.*

### Rhode Island Medico-Legal Society.

The regular quarterly meeting of the Rhode Island Medico-Legal Society was called to order, by the President, at 5:30 P. M., April 30, 1925. There were twenty members and five guests present. The minutes of the last meeting, also of the special meeting of March 17, 1925, were read and approved. The report of the Treasurer was read and accepted. The name of Henry F. Burt was presented for membership and elected. There being no further business, Honorable Antonio A. Capotosto of Providence, Associate Justice of the Superior Court of Rhode Island, was introduced and spoke on "The Revolution of the Day as Viewed from the American Viewpoint."

In speaking, he said: "Like out of calm comes a severe illness, the family gropes for help, the physician is called and diagnosis, and convalescence comes, following a crisis. So it was with the world, at peace in 1914, the crisis was the war and the recovery the readjustments since. The Russian reaction was complete disunion of capital and labor, the will of the mass to control the destiny of their people. Briton reacted Labor and Social in the McDonald overthrow. Spain's revolution against social order by labor. Italy had a silent revolution for order aganist forces of disorder, as the masses intended to tear down. He fears the American attitude of indifference, which he believes is dangerous, yet the United States refuses Russia recognition because she represents the forces of disorganization. He believes Mussolini should be congratulated instead of condemned, from an American viewpoint. Germany's condition should be watched as possibly, by the strong arm of arms, may arise with a new moral standard, thus combating again communism." A live subject was well presented.

In discussion, Drs. Skelton, Richards, Ruggles, Jones; Messrs. Tanner and Littlefield spoke of disarmament, disarmament agreements, immigration and racial differences and many very valuable questions were answered by the speaker, Judge Capotosto.

Jacob S. Kelley
*Secretary.*

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### Rhode Island Ophthalmological and Otological Society.

The annual meeting of the Rhode Island Ophthalmological and Otological Society was held, through the courtesy of the retiring president, Dr. Adams, at the University Club, Friday evening, at 7 P. M., September 4, 1925.

The following officers were elected for the coming year: President, Jeffrey J. Walsh, M.D., Vice-President, John J. Gilbert, M.D., Secretary-Treasurer, Francis P. Sargent, M.D.

The annual report of the Secretary-Treasurer was read and accepted.

It was voted to pay the usual $25.00 to the Rhode Island Medical Library Fund, and to subscribe to the Eye, Ear, Nose and Throat Journals, for the Medical Library.

The following members constitute the Standing Committee for the coming year: Howard E. Blanchard, M.D., William C. McLaughlin, M.D., Frank M. Adams, M.D.

Meeting adjourned at 9:30 P. M.

Francis P. Sargent,
*Secretary*

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### American Board of Otolaryngology

An examination was held by the American Board of Otolaryngology on May 26, 1925, at the Medico-Chirurgical Hospital, Philadelphia, with the following result: Passed 137, failed 20, total examined 157.

The next examination will be held at the University of Illinois School of Medicine on October 19, 1925. Applications may be secured from the Secretary, Dr. H. W. Loeb, 1402 South Grand Boulevard, St. Louis, Missouri.

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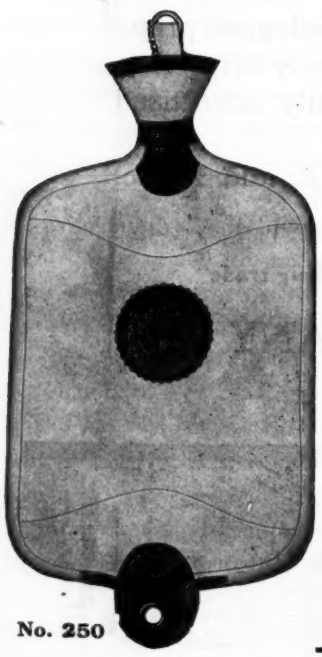

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